MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES
SECTION FOR MEDICAL MARIJUANA REGULATION
MEDICAL MARIJUANA REGULATORY PROGRAM

MEDICAL MARIJUANA PHYSICIAN COMPLAINT FORM

Complaints regarding licensed physicians who certify patients with qualifying medical conditions for the use of medical marijuana will be received pursuant to the Department's authority in 19 CSR 30-95.110(3) to conduct physician investigations.

Complaints and associated documents are public records, including all identifying information of the complainant. However, pursuant to Article XIV, Section 1.3(5), confidential information related to patients will be redacted before any public release of the complaint form.

A separate form should be submitted for each complaint unless the same physician(s) are involved. Once complete, submit the form and any attachments to: **mmcomplaints@health.mo.gov with subject "Attention: Physician Complaint".**

CERTIFYING PHYSICIAN INFORMATION

PHYSICIAN NAME [1]	PHYSICIAN LICENSE NUMBER IF KNOWN [2]
PHYSICIAN'S ADDRESS [3]	PHYSICIAN'S PHONE NUMBER IF KNOWN [4]

COMPLAINANT CONTACT INFORMATION

NAME [5]		DATE COMPLAINT FILED
ASSOCIATION TO PHYSICIAN [6]	REPRESENTING ORGANIZATION AND TITLE, IF APPLICABLE [7]	
PHONE NUMBER	EMAIL	
ADDRESS 1	ADDRESS 2	
CITY	STATE	ZIP

CHECK ALL THE CATEGORIES THAT APPLY BELOW [8]

DATE(S) ACTION(S) OBSERVED [9]

- ☐ Physician does not meet requirements of a certifying physician pursuant to 19 CSR 30-95.010(29)
- ☐ Physician is not examining qualifying patients and reviewing their medical records or medical history as required pursuant to 19 CSR 30-95.110(1)(B)8.B.
- ☐ Physician is not discussing with patients the potential risks associated with medical marijuana, including known contraindications as required pursuant to 19 CSR 30-95.110(1)(B)8.D.
- ☐ Physician is allowing others to sign physician certification forms in violation of 19 CSR 30.110(1)(B)9.
- ☐ Physician is falsifying information on certifications
- ☐ Physician is selling and/or distributing medical marijuana
- ☐ Other complaint

PROVIDE DETAILS SUPPORTING THE COMPLAINT [10]

ARE SUPPORTING DOCUMENTS ATTACHED? ☐ YES ☐ NO

IF YES, PLEASE LIST.

SIGNATURE	DATE

Submit this form to: mmcomplaints@health.mo.gov with subject "Attention: Patient/Caregiver Complaint".

[1]Physician name refers to the name of the physician against whom the complaint is being filed.
[2]Physician license number refers to the license number issued by the Missouri Professional Board of Registration. Include this information ifavailable.
[3]Physician address is the address of the physician's office location or the address the physician lists on their physician certification forms.
[4]Physician phone number is the phone number at the physician's office or phone number the physician lists on their physician certification forms.
[5]Name and contact information for the person submitting the complaint.
[6]Association to physician refers to how the person submitting the complaint is associated with the physician if applicable (i.e., patient, familymember of patient, attended physician event, etc.)
[7]Representing Organization and Title should be included when this form is being used by law enforcement or another agency to contact theprogram in an official capacity.

[8]Check the violations the complainant believes the physician has committed.
[9]Include all dates the actions at issue were observed.
[10]Provide any comments or information that may help the Department review the potential violations.

AGENCY USE ONLY

DHSS STAFF ASSIGNED		DATE RECEIVED
REQUIRED INFORMATION PROVIDED ☐ YES ☐ NO	IF YES, SUPPORTING DOCUMENTS UPLOADED TO DATABASE ☐ YES ☐ NO	IF YES, DATE FORWARDED TO INVESTIGATION MANAGER
IF NO, DATE RESPONSE SENT TO COMPLAINANT	COMPLAINT REDIRECTED TO ANOTHER STATE AGENCY ☐ YES ☐ NO	NAME OF RECEIVING STATE AGENCY
NAME OF RECEIVING AGENCY CONTACT	CONTACT EMAIL ADDRESS	CONTACT PHONE NUMBER

NOTES

INVESTIGATION MANAGER SECTION

INVESTIGATION MANAGER ASSIGNED	COMPLAINT CATEGORY ☐ CATEGORY 1 ☐ CATEGORY 2

APPROPRIATE ACTION
☐ INITIATE INVESTIGATION ☐ NOT PURSUING FURTHER ☐ REDIRECT TO ANOTHER STATE AGENCY

IF INVESTIGATION INITIATED, COMPLETE THE FOLLOWING FIELDS

ASSIGNED COMPLIANCE OFFICER NAME	PATIENT SERVICES DIRECTOR NOTIFIED ☐ YES ☐ NO	DATE PATIENT SERVICES DIRECTOR NOTIFIED

DATE RESPONSE SENT TO COMPLAINANT

IF REDIRECTED TO ANOTHER STATE AGENCY, COMPLETE THE FOLLOWING FIELDS

NAME OF RECEIVING STATE AGENCY	NAME OF RECEIVING AGENCY CONTACT
CONTACT EMAIL ADDRESS	CONTACT PHONE NUMBER

NOTES